General

Guideline Title

UK national guidelines on the management of adult and adolescent complainants of sexual assault 2011.

Bibliographic Source(s)

Clinical Effectiveness Group. UK national guidelines on the management of adult and adolescent complainants of sexual assault 2011. London (UK): British Association for Sexual Health and HIV; 2012 Jun. 50 p. [92 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previously version: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guidelines on the management of adult victims of sexual assault. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p. [19 references]

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- May 12, 2016 – Fluoroquinolone Antibacterial Drugs : The U.S. Food and Drug Administration (FDA) is advising that the serious side effects associated with fluoroquinolone antibacterial drugs generally outweigh the benefits for patients with sinusitis, bronchitis, and uncomplicated urinary tract infections who have other treatment options. For patients with these conditions, fluoroquinolones should be reserved for those who do not have alternative treatment options.

Recommendations

Major Recommendations

The levels of evidence (I-IV) and grades of recommendation (A-C) are defined at the end of the "Major Recommendations" field.

What's New in These Guidelines

These guidelines update and replace the 2001 British Association for Sexual Health and HIV (BASHH) Guidelines on the management of adult victims of sexual assault. Updated areas include:

- Updated advice on prophylaxis of sexually transmitted infections - new treatment for gonorrhoea (updated June 2012) based on the *2011 Management of Gonorrhoea* BASHH guidelines
- Issues of consent, confidentiality and disclosure of medical records
- Legal frameworks on sexual offences
- Sexual Assault Referral Centres (SARCs)
- Forensic aspects of sexual assault
- Aftercare following sexual assault
- Self-harm risk identification
- Prophylaxis of pregnancy and some sexually transmitted infections (STIs)
- Psychological consequences of sexual assault
- Vulnerable groups
- Psychosocial support

Service Availability and Staffing

It is considered good practice to:

- Respect the clients wishes as far as possible
- Offer a suitable appointment such as a fast-tracked or booked appointment to anyone identified as a complainant of sexual assault, with a minimum waiting time
- Offer an experienced doctor or a nurse, with a choice of female or male gender where possible
- Offer a non-judgmental, supportive and safe environment
- Maintain training in communication skills amongst all staff groups
- Encourage all staff dealing with sexual assault to have the knowledge of forensic timeframes and aftercare aspects of sexual assault, as well as child protection, domestic violence and self-harm risk identification issues
- Ensure local police are aware of the clinic and that staff have contact information for local (SARCs), police stations and specialist sexual offences police units, as well as social services, child protection agencies, local mental health departments, general practitioners and voluntary organisations such as Victim Support, Rape Crisis Centers, Survivors UK, Respond and others (see Appendix 1, List of National Helplines, in the original guideline document).

Documentation

Careful documentation in clinical notes is essential. The notes may form a part of the evidence in the criminal justice process, with the clinician later being requested to provide a statement and disclose notes. Clinical notes can be requested for disclosure by the Police, the Crown Prosecution Service (CPS), barristers acting for the Defence in criminal proceedings or lawyers acting on behalf of clients in civil proceedings.

Health care professionals seeing the complainant may be asked to write a medical report at a later date for legal or compensation purposes. A copy of the original notes may be requested for disclosure if there is a court case and minor discrepancies between records may be used by the Defence barrister to discredit the complainant. Thus, the examination should be conducted and the findings documented very carefully. Some centers use a specific pro-forma. It is good practice to record sentences verbatim where appropriate (e.g., the assailant had said: 'I will hurt you, if you scream').

A brief history of the assault should be recorded in the genitourinary medicine (GUM) clinical notes concentrating on what happened, when, where and by whom. This will help in understanding the scenario and will assist in deciding about sites for STI swabs as well as the possible need for psychosocial support.

Consent, Confidentiality and Disclosure of Notes

Assess Gillick competence in all under-16 year olds. Obtain consent for examination and give information about confidentiality and disclosure of recorded information, documenting the discussion in the notes. If the assault is subsequently reported to the police, they may request disclosure of information divulged during the consultation. In particular, disclosure of counseling or psychology notes for court purposes may generate anxiety about the potential impact they may have on criminal proceedings, due to the very personal nature of such consultations. It is important to balance protecting the client's confidentiality with assisting the criminal justice system. The information provided may be useful to the CPS in preparation of the case for court. It is better for vulnerabilities to be highlighted at an early stage. This will enable the CPS to present the case to court in an appropriate manner, minimizing the chances of the complainant being discredited by the Defence. Appendix 3 in the original guideline document summarises the request for disclosure of information. If in doubt:

- Follow your local Trust's disclosure policy.
- Seek advice from experienced colleagues, the Trust's legal department, the General Medical Council (GMC) or your defence union.

Needs Following Sexual Assault

The client's needs following a sexual assault depend on the time of presentation and can be classified as: immediate, medium and longer term. Appendix 4 in the original guideline document summarises pathways depending on the presentation and type of referral for any setting where complainants of sexual assault may present soon after an assault. Readers are encouraged to adapt it for local use.

Immediate Needs (Disclosure Within 7 Days of Assault)

Consider the following, although not all will be applicable to (or accepted by) the client

- Immediate safety
- Treatment of injuries
- Offer of baseline screening for STIs and/or prophylaxis for bacterial STIs
    - Follow-up schedule is adapted accordingly. See Appendix 6 in the original guideline document
- Baseline human immunodeficiency virus (HIV) test or save serum sample
- HIV post-exposure prophylaxis post-sexual assault (PEPSE) (within 72 hours)
- Hepatitis B vaccination (and hepatitis B immunoglobulin if assailant likely or known to be surface antigen carrier)
- Prevention of pregnancy
- Consider referral for forensic medical examination (FME) in a local SARC to gather deoxyribonucleic acid (DNA) evidence and document any injuries
- Be aware of any child and vulnerable adult protection issues
- Carry out self-harm risk identification (Appendix 5, forms 1 & 2, in the original guideline document)

Medium Term Needs (Disclosure After 7 Days of Assault)

- Screening for STIs at baseline and/or 2 weeks after the assault
- Hepatitis B vaccination as appropriate
- Pregnancy testing as appropriate
- Assessment of coping abilities
- Identify symptoms of post-traumatic stress disorder (PTSD)
- Practical and psychosocial support

Long Term Needs (Disclosure After 1 Year Post-assault)

Sexual health clinic staff may be told of an historical assault. STI screening may be offered. Psychological problems are best dealt with the involvement of the client's general practitioner (GP) and appropriate referrals made for counseling or psychological treatment. A detailed assessment and management of the psychological consequences of sexual assault is not expected in the general genitourinary setting, however awareness of symptoms and knowledge of referral and treatment options will be beneficial.

With PTSD

Those with severe post-traumatic symptoms, or with severe PTSD in the first month after the traumatic event, can benefit from cognitive and behavioral therapy (CBT) or eye movement desensitisation and reprocessing (EMDR). Anti-depressant medication may also be prescribed, but should not be used as a routine first-line treatment for adults in preference to a trauma-focused psychological therapy.

Without PTSD

Counseling, psychotherapy or psychological therapy can be offered to clients who do not have PTSD but are having ongoing psychological difficulties following the assault. It should be remembered that only some psychological interventions are allowed in cases awaiting a trial, in order to prevent their impact on the proceedings.

Basic Changes to the Law on Sexual Offences

An awareness of the basic law on sexual offences is helpful when discussing with the client the reporting of the assault to the police and the need for a forensic medical examination. The Sexual Offences Act 2003 (England & Wales), Sexual Offences Order 2008 (Northern Ireland) and Sexual Offences Act 2009 (Scotland) all provide a statutory framework for sexual offences in the United Kingdom (UK). Key changes in the law on sexual offences include the following:

- Inclusion of oral penile penetration in the definition of 'rape'
- Recognition of an assault by penetration with an object such as a finger
- The definition of consent is defined as "free agreement"
- Sexual behaviour towards children is addressed by maintaining the age of consent at 16 years of age
- Sexual activity of any kind between adults and children under the age of 16 is deemed unlawful
- Separate 'protective' offences are provided for, in respect of sexual activity with young children (under the age of 13) and older children (from age 13 to age 15)
- Sexual intercourse and oral sex between under-16s remains unlawful and it is an offence for a person in a position of trust over a child under the age of 18, or a person with a mental disorder, to engage in sexual activity with that child or person

Aspects of Forensic Medical Examination (FME)

Carrying out an FME is outside the scope of these guidelines and would not be expected to be undertaken in a general GUM setting by physicians not trained in the forensic aspects of sexual assault. Not everyone who has been sexually assaulted will want to report the assault to the police or have forensic evidence gathered.

An increasing number of SARCs have been set up in the UK (see Appendix 2 in the original guideline document). These are specialist units where complainants of sexual assault can have forensic evidence gathered, injuries documented and immediate medical aftercare and psychosocial support facilitated. There are different models of SARCs, not all of which offer STI screening, which is usually carried out in a local GUM clinic.

If an FME is required, it can be arranged by suggesting the reporting of the assault to the Police who will facilitate it, or by contacting the nearest SARC who may be able to offer an FME without police involvement (see Appendix 2 in the original guideline document).

FME with Police Involvement

- Those who wish to report the assault to the police immediately should be encouraged to do so
- Have the contact numbers of the local police station readily available
- Specialist police officers trained in the management of complainants of sexual assault will take a brief first account of the incident and arrange an FME
- The officers may use an early evidence kit (see below) and arrange an FME in a SARC or a non-SARC setting, depending upon local arrangements

FME Without Police Involvement

- The wishes of those who disclose recent sexual assault but do not wish to report the offence to the police should be respected.
- Some SARCs offer an FME with collection of DNA and other evidence, without police involvement. This gives clients the opportunity to consider their options and report the assault at a later date. Options for non-police referrals include:
    - Testing of anonymous forensic samples
    - Storage of anonymous forensic samples without testing
    - Release of police intelligence information with the samples
    - Release of police intelligence information without samples
    - Independent trained police officer advice
    - Revisiting decisions regarding testing and/or reporting

Forensic Timescales

Knowledge of forensic timescales (see the table below) and the choices that are available in a SARC setting can help the genitourinary (GU) physician give appropriate advice and facilitate an appropriate referral. DNA can be gathered for up to 7 days after vaginal penetration, up to 2 days in oral penetration and for up to 3 days in anal/penile penetration irrespective of washing or bathing.

Table: Forensic Timescales (Persistence of DNA)

Type of Assault	Female	Male
Kissing, licking, biting	48 hours or longer	48 hours or longer
Oral penetration	48 hours (2 days)	48 hours (2 days)
Vaginal penetration	7 days	n/a

Type of Assault	Female	Male
Digital penetration	12 hours	12 hours
Anal penetration	72 hours (3 days)	72 hours (3 days)

Abbreviation: n/a, not applicable

Be aware of the short detection times of substances which may be used in drug facilitated sexual assaults (DFSA). Blood and urine samples should be collected within 3 and 4 days respectively.

In delayed presentation in cases suspected of DFSA, it is possible to carry out hair analysis seeking a single dosage of drugs after one month of ingestion; however this is not done routinely and is considered on an individual case-by-case basis.

Advise clients about preserving forensic evidence if possible by avoiding bathing, washing clothes, brushing teeth or drinking liquids prior to an FME, as well as the preservation of sanitary pads, tampons and clothes (particularly underwear) worn at the time of the assault and immediately after the assault. If DFSA is suspected, advise not to dye hair as this interferes with toxicology results in hair.

Early Evidence Kits (EEKs)

EEKs which contain a urine sample pot, mouth swab and mouth rinse are now available in many police forces, allowing early collection of DNA evidence and toxicology. Having an EEK in the GUM setting may assist in the early collection of forensic evidence in those who present in this setting, within the first few days following an assault. When gathering EEK samples, Chain of Evidence should be demonstrated (see below).

Forensic Significance of Positive STI Results

The identification of an STI rarely assumes evidential importance, as prior acquisition would have to be excluded. In 1993 Ledray expressed concern that the presentation of positive STI findings in court may hurt rather than help a victim's case by presenting him/her as 'promiscuous'. The presence of an STI may assume evidential importance when diagnosed in a child, the elderly and a sexually inexperienced orifice in an adult (for example ano-rectal gonorrhea in a heterosexual male who has been sexually assaulted). It may occasionally be used to link the perpetrator with the victim in sexually experienced individuals. Under such circumstances, it is advisable to demonstrate a Chain of Evidence of the custody of the samples. This refers to the chronological documentation from collection, transfer and analysis, of all the samples taken from the client. The Royal College of Pathologists has published guidelines on handling medico-legal specimens and preserving the chain of evidence. All GUM/sexual health clinics should consider the need to have policies and procedures in place for chain of evidence, but it is acknowledged that not all GU services can offer such provision. In cases where criminal proceedings may be anticipated, liaison with local Police or SARC services will help with appropriate management. Medico-legal protocols ought to be agreed with the laboratory (e.g., isolates of gonorrhoea can be stored and typed and nucleic acid amplification tests [NAATs] retested using different platform). Finding an STI may influence the level of criminal injuries compensation awarded to the client. Applying for compensation before the criminal trial is not advisable due to the potential for it to be used against the client.

Aftercare Following Sexual Assault

Those presenting within forensic timescales for DNA collection who opt not to have an FME and those presenting beyond forensic timescales should be offered aftercare appropriate to the time of presentation, type of exposure and risk factors, with emergency contraception, the offer of prophylaxis against certain STIs, risk assessment and safety being a priority.

History Taking

- This should be especially sensitive and unhurried, respecting the wishes of the client.
- A brief history of the assault including: date, time, location, number of perpetrators, perpetrator characteristics (stranger, partner, ex-partner, acquaintance), physical violence, presence of injuries (new and old), sexual acts (vaginal, oral, anal, penile/digital penetration), ejaculation and condom use. Some will not disclose forced oral or anal penetration without being directly asked, due to embarrassment.
- Pre- and post-assault sexual history
- Presenting symptoms (e.g., vaginal/anal pain or bleeding)
- Risk of viral infections (HIV, hepatitis B and C) in the perpetrator, if known
- Past medical, surgical, gynecological, obstetric history and mental health history
- Menstrual and contraceptive history
- Prescription and non-prescription medication and allergies

Examination

- Examination should be carried out with privacy in an unhurried and sensitive manner with good documentation of the findings.

- If the assault is recent, ask about any injuries and refer to Accident and Emergency (A&E) if they require treatment.
- Genital examination may be a reminder of the assault and some clients may be reluctant to have it done. Respect their wishes.
- In historical cases where an adolescent girl discloses a past history of vaginal penetration by a penis or another object such as finger, interpretation of hymenal findings may be useful evidentially and knowledge of how to examine and describe hymenal findings is beneficial. Referral to the local SARC or a community pediatrician for photo-documentation of genital findings using a colposcope should be considered.
- In females, carry out an internal vaginal examination using Cusco's speculum, inspecting for injuries and possible signs of infection.
- In males, examine the genitalia and peri-anal area, looking for injuries and possible signs of infection.
- In both sexes with a history of oral penetration inspect the oral cavity for the presence of injuries mainly, as STIs at this site are usually asymptomatic.
- Consider proctoscopy in cases with a history of anal penetration, noting any recent or old ano-rectal trauma and signs of infection.

Investigations for STIs (see also the latest testing guidelines from BASHH)

In those without symptoms or those who do not wish to have a speculum examination, offer non-invasive tests such as self-taken or physician-taken vulvo-vaginal swabs or urine tests. Anal internal examinations and swabs are sometimes refused or delayed by both females and males who have been anally penetrated. Proceed at their pace and allow them to be in control over this process.

If the client presents within 2 weeks of the assault, consider STI screening at baseline using NAATs if appropriate and repeat tests 2 weeks after exposure. Be aware that there is a high rate of default from subsequent appointments, so a pragmatic approach to management may have to be taken.

Currently, NAATs are recommended for the diagnosis of *Chlamydia trachomatis* as they show superior sensitivity and specificity to other tests. Every positive chlamydia result should be confirmed using another NAAT, preferably of equal sensitivity but with a different target. NAATs are the tests of choice for urethral, cervical, vaginal (self-taken or physician-taken), rectal and pharyngeal infections and first catch urine specimens in men. The reader is advised to refer to the BASHH *Chlamydia* testing guidelines for more up-to-date advice (see the BASHH website).

Clinicians should be aware of the potential for false-positive results regardless of the site tested, particularly when using the test in a low prevalence population. When the test result is equivocal, arrangements should be made to re-test the original sample and request a further sample. Where possible this sample should be tested using a NAAT assay of equal sensitivity but with a different target.

Asymptomatic Screening

- Cultures for *Neisseria gonorrhoea* and dual nucleic acid amplification techniques tests for *Chlamydia trachomatis* from any site of penetration or attempted penetration (vagina: urethra, cervix; rectum or throat). The sensitivity of testing urine using a NAAT to identify gonococcal infection in women is lower than testing an endocervical specimen.

Symptomatic Screening

- Vaginal wet slides for microscopy for yeasts, bacterial vaginosis and *Trichomonas vaginalis* (TV). If available, culture for TV.
- Gram stained slides for microscopy for gram negative diplococci from site(s) of penetration or attempted penetration excluding pharynx where culture for gonorrhoea should be taken.
- Cultures for *Neisseria gonorrhoea* and dual nucleic acid amplification techniques tests for *Chlamydia trachomatis* from any site of penetration or attempted penetration (vagina: urethra, cervix; rectum, throat).

Baseline Bloods

Presentation Within 3 Months

- Syphilis serology
- Hepatitis B and C serology
- HIV serology

There may be pre-existing infections. Serum samples saved immediately, or soon after the disclosure of sexual assault, can be tested after 3 months if any of the above mentioned blood tests are positive, as negative saved serum may indicate an association between the alleged assault and the acquisition of infection.

Presentation Over 3 Months

- Syphilis serology
- Hepatitis B and C serology
- HIV serology

When HIV Post-Exposure Prophylaxis After Sexual Exposure (PEPSE) Is Prescribed at Commencement of Treatment

(NB: Recommendations may change - please see the latest BASHH guidelines on PEPSE .)

- Baseline HIV serology
- Syphilis serology
- Hepatitis B and C serology
- Full blood count (FBC)
- Liver function tests (LFTs)
- Urea and electrolytes (U&E)
- Glucose
- Lipids
- Amylase

Prophylaxis of Bacterial STIs

Gonorrhoea, chlamydia and trichomoniasis are the infections most frequently identified in women who present with a history of sexual assault. The peak age for sexual assault is similar to that of many STIs, so their presence does not necessarily indicate acquisition as a result of the assault.

Prophylaxis against STIs can be offered as part of immediate medical aftercare post sexual assault. Using bacterial prophylaxis may reduce the need for tests, decrease the chances of detecting a bacterial STI and lessen the chance of missing an infection in cases of default from follow up. The advantages of bacterial prophylaxis have to be weighed against disadvantages. These include unnecessary treatment, reinforcing belief that there was a high risk of infection (which in itself may raise levels of anxiety) and missing out on partner notification, if the source of infection was someone other than the assailant, leading to the possibility of re-infection by a regular or known sexual partner. In situations where the client may default, is unable to tolerate the distress of a repeat examination or requires an intrauterine device (IUD) for emergency contraception, prophylactic treatment with antibiotics which cover gonorrhoea, chlamydia and trichomoniasis may be offered (see the table below). Weigh up advantages of giving metronidazole in a stat 2 g oral dose against its potential for causing vomiting and thus a potential reduction of the efficacy of any emergency oral contraception.

Table: Recommended Regimens (Adult Doses) (IV, C - UK National Guidelines - BASHH Clinical Effectiveness Group). See the latest appropriate BASHH guidelines for up-to-date advice on treatment options.

Gonorrhoea	Ceftriaxone 500 mg IM as a single stat dose + azithromycin 1 g PO stat
Chlamydia	Azithromycin 1 g PO single stat dose (not needed if azithromycin is given with ceftriaxone as above)
TV	Metronidazole 2 g PO single stat dose

Abbreviation: TV, *Trichomonas vaginalis*

Treatment of Uncomplicated Gonorrhoea and Chlamydia in Pregnancy or Breastfeeding

Due to the emergence of resistance of gonorrhoea to cefixime, ceftriaxone 500 mg as a single intramuscular injection plus azithromycin 1 g po stat are recommended as the first line treatment. The safety of azithromycin in pregnancy and breastfeeding has not been fully studied; however it is regarded as safe and can be used as first line treatment. If the patient refuses injectable treatment or is needle phobic, cefixime 400 mg stat orally can be given as an alternative to the ceftriaxone.

Treatment of Gonorrhoea in Allergy to Penicillin

Ciprofloxacin 500 mg orally as a single stat dose if the organism is known to be sensitive and the patient is not pregnant or breastfeeding. Alternatively, spectinomycin 2 g intramuscularly as a single stat dose or azithromycin 2 g orally stat can be used.

Treatment of Uncomplicated Pharyngeal and Rectal Gonorrhoea

Ceftriaxone 500 mg intramuscularly stat plus azithromycin 1 g po stat, or ciprofloxacin 500 mg orally as a stat dose or ofloxacin 400 mg orally as a stat dose.

Epidemiological Treatment of Gonorrhoea in a Sexual Assault Referral Centre Setting with Low Gonorrhoea Prevalence

- In view of the emergence of resistance of gonorrhoea to cefixime, it is preferable to refer patients for testing and treatment (with injectable ceftriaxone) to a local sexual health clinic.
- If the patient does not wish to go for testing and treatment or is more likely to default from follow up, the most sensible option is cefixime 400 mg orally stat plus azithromycin 1 g orally stat. Do not use ciprofloxacin, unless there is a history of cephalosporin allergy or severe penicillin allergy.

Those who have accepted prophylaxis should be offered full STI screening after treatment to exclude the possibility of treatment failure or re-infection if the source of infection was a regular partner. Evidence for the efficacy of antibacterial prophylaxis is limited. Avoidance of unprotected sexual intercourse until they have had STI screening and, in the case of a positive STI diagnosis, partner notification, should be advised. Those aged less than 18 years of age should be particularly encouraged to attend for follow up to offer screening for STIs, assess risks (child protection and self-harm) and consider contraceptive advice and sexual health promotion.

Prophylaxis of Viral STIs

The assailant is known to the complainant in the majority of cases and the anxieties of a woman assaulted by a known sexual partner, particularly with regard to HIV, may be very different to that of a woman assaulted by a stranger.

HIV Post-Exposure Prophylaxis After Sexual Exposure (HIV PEPSE)

- HIV PEPSE should be discussed, documented and offered depending on the risk assessment as soon as possible after unprotected exposure but no later than 72 hours post assault. GUM clinics should work closely with their local SARCs in immediate HIV PEPSE provision and/or follow up.
- Advice should be given concerning the lack of conclusive data about the efficacy and long-term toxicity of HIV PEPSE, as well as possible side effects, length of treatment, importance of adherence and frequency of follow up as well as baseline blood tests including HIV.
- Carry out HIV risk assessment - see Tables 4-9 in the original guideline document. The risk of transmission and prevalence tables are awaiting an update. For more up to date information refer to the most recent BASHH/BHIVA guidelines.

HIV PEPSE Combinations

HIV PEPSE in adults generally comprises 2 x nucleoside reverse transcriptase inhibitors and 1 x protease inhibitor (boosted) for 28 days. The antiretrovirals used are unlicensed for PEPSE. The cost of a 28 day course is about £650. Starter packs usually contain a few days worth of medication. For the most up to date combinations of antiretrovirals used as HIV PEPSE, refer to the latest BASHH guidelines .

Table: HIV PEPSE Regimens as per Department of Health/Expert Advisory Group on AIDS (DH/EAGA) PEP Guidelines

Drug	Constituents	Dose	Duration
Truvada®	Tenofovir & emtricitabine	ONE tablet ONCE a day with or without food	28 days
Kaletra®	Lopinavir & ritonavir	TWO tablets TWICE a day with or without food	28 days

Treatment of Side Effects

Side effects include nausea, vomiting and diarrhoea. Supportive therapies should be provided (see the table below).

Table: Supportive Treatment in HIV PEPSE

Domperidone	10 mg tablet	ONE tablet THREE times a day when needed for nausea or vomiting. Maximum of 8 tablets in 24 hours	Pack of 30
Loperamide	2 mg tablet	TWO tablets at the first sign of diarrhoea then ONE tablet when needed thereafter. Maximum of 8 tablets in 24 hours	Pack of 30

Drug Interactions

Kaletra® (lopinavir and ritonavir) reduces the effect of the contraceptive pill through induction of hepatic enzyme activity. Additional barrier

contraception such as condoms should be advised to those on the combined oral contraceptive pill, patch, an implant (Implanon®) or a progesterone only pill. The dose of a combined oral contraceptive pill should be adjusted to provide 50 micrograms or more of ethinylestradiol.

HIV PEPSE for Children and Low Weight Adults

Advice should be sought from an HIV specialist/paediatrician from a local HIV network. The guidance from the Children's HIV Association is that the management of children with HIV in the UK should be according to the current version of the PENTA (Paediatric European Network for the Treatment of AIDS) guidelines (see www.pentatrials.org). Currently this is a 2009 document.

Adults who weigh ≤40 kilograms will need to have their dosage calculated with advice from an HIV physician/pharmacist.

HIV PEPSE in Pregnancy

Pregnancy does not preclude the use of HIV PEPSE; however, drugs used as post-exposure prophylaxis (PEP) are not licensed for use in pregnancy. Once again, it is good practice to seek advice from an HIV specialist.

Hepatitis B

Acquisition of Hepatitis B following sexual assault in the UK is very rare. BASHH guidelines recommend that Hepatitis B vaccine may be considered in those who give a history of a sexual assault up to 6 weeks previously, in particular when there was high risk exposure. See the table below.

Table: Risk Factors for Hepatitis B and Indications for Hepatitis B Vaccine

- Assailant known to be a hepatitis B carrier
- Assailant has risk factors (intravenous drug users [IVDU], men having sex with men, high prevalence area)
- Anal rape
- Trauma and bleeding
- Multiple assailants
- Client wishes to be vaccinated
- Client not known to be immune to hepatitis B following vaccination

Prophylaxis of Hepatitis B Infection

Previous Vaccination

Increasing numbers of people have now been vaccinated for occupational or other reasons; if there is a good history of at least three vaccinations having been given, and ideally of a subsequent check for immunity, then vaccine need not be given but a blood sample is recommended to check for immunity (anti-HBs). If there is any doubt about completion of or time elapsed since previous vaccination, offer a booster.

Immunoglobulin

Immunoglobulin should be considered within 48 hours and no later than 7 days after a known infectious contact and may be given to a non-immune contact after a single unprotected sexual exposure, if the assailant is known or strongly suspected to have hepatitis B.

Hepatitis B Vaccination

There is a theoretical possibility that a very rapid course of Hepatitis B vaccination given within 6 weeks of sexual exposure, apart from offering long term protection, will prevent the development of Hepatitis B infection in those at risk. Hepatitis B vaccination may not be appropriate in clients assaulted by a long-term partner; they should be offered screening instead.

Hepatitis B	Immunoglobulin 500 international units (i.u.) intramuscular (IM) (best within 48 hours) no later than 7 days of an known infectious or strongly suspected contact to non-immune individuals Hepatitis B vaccination 1 ml IM in adults and adolescents >13 yrs of age within 6 weeks of exposure (Engerix B 3 x 20 mcg; HBvaxPro 3 x 10 mcg)

Hepatitis B Vaccine Schedules

Very rapid course of hepatitis B vaccination given at 0, 7 and 21 days post exposure or an accelerated course at baseline, 1 month and 2 months post exposure followed by a booster at one year, is recommended.

Very rapid schedule (super accelerated)	At 0, 7, 21 days post exposure with a booster at 12 months
Accelerated schedule	At 0, 1, 2 months post exposure with a booster at 12 months

Follow Up After Sexual Assault (see also Appendix 6 in the original guideline document)

- Offer first HIV PEPSE follow-up appointment before starter pack finishes (usually 3-5 days) and carry out baseline bloods if not already done, review the wish to continue, side effects and compliance followed by weekly (if problems) or two weekly (if no problems) follow up appointments until completion of the course.
- Offer STI screening at baseline and/or 2 weeks after the alleged assault.
- Do baseline bloods for syphilis, hepatitis B and C depending on risk assessment at first follow up appointment.
- Offer hepatitis B vaccination within 6 weeks of assault and complete within the timeframe dictated by chosen schedule.
- Carry out risk identification (child protection, self-harm, domestic violence).
- Carry out pregnancy testing where and when applicable.
- Review psychosocial needs and coping.
- Use of 4th generation HIV tests (for both HIV antibodies and p24 antigen) is recommended.
- Offer HIV test at 3 months post assault (or 3 months post completion of HIV PEPSE if given).
- Consider HIV test 1 months post high-risk exposure if 4th generation HIV tests are used.
- Offer serological tests for hepatitis B, C and syphilis at 3 months post assault.
- Consider repeating tests at 6 months for hepatitis B and HIV as late seroconversion has been documented.

Pregnancy Prevention

Rape carries a 5% risk of pregnancy.

Copper Intrauterine Contraceptive Device (CuIUD)

A copper IUD, due its low failure rate and its potential for use as an ongoing method of contraception, ought to be discussed with all women presenting within 5 days after an episode of unprotected sexual exposure. The CuIUD can be fitted at any time in the menstrual cycle, provided the assault is the only unprotected sex that has occurred since the last menstrual period and was within 5 days. If unprotected sexual activity had taken place more than once since the last period then an emergency CuIUD can be fitted up to day 19 of a 28 day menstrual cycle.

There may be logistical difficulties with providing CuIUD as emergency contraception in some GU clinics; local referral pathways for emergency CuIUDs should be in place. If the victim chooses not to have a coil, or is too distressed, hormonal methods should be offered.

Hormonal Emergency Contraception

Levonelle 1500® as a single dose (i.e., 1.5 mg) may be given up to 5 days after the assault (it is licensed for up to 72 hours but it may be still effective for up to 120 hours after sexual exposure). The dose of Levonelle should be doubled (i.e., 3 mg) for those taking liver enzyme-inducing drugs. Those starting HIV PEPSE at the same time should use condoms. The issue of emergency contraception and simultaneous administration HIV PEPSE raises questions about efficacy and toxicity. Some clinicians would choose to use a double dose of emergency contraception in case ritonavir reduces levels. Whilst this may not be necessary, there does not appear to be any increase in toxicity.

A new emergency contraceptive, Ellaone®, containing 30 mg of ulipristal, a selective progesterone receptor modulator, can be given for up to 120 hours after unprotected sexual exposure. It should not be given in pregnancy and a pregnancy test is recommended prior to administration.

Pregnancy Following Sexual Assault

If a pregnancy test is positive, discuss options which include:

- Continuing with the pregnancy
- Termination of pregnancy
- Paternity testing
- Using products of conception as evidence

If the client continues with a pregnancy, make a referral to a GP or an antenatal clinic and share relevant information about the assault, with the

client's consent. If the client wishes to terminate the pregnancy, the fetus can be used as DNA evidence. Arrangements should be made for the collection of products of conception by the investigating police officer, demonstrating chain of evidence. If there is uncertainty about who the father is, the assailant or a partner, paternity testing using chorionic villous biopsy can assist in making a decision about whether to keep or terminate the pregnancy. The procedure should be arranged via a local gynaecology department (there may be funding issues to consider).

Partner Notification (Contact Tracing)

Arrangements should be in place for the management and treatment of all sexual partners of clients found to have an STI. Clients and partners should abstain from sexual intercourse until treatment has been completed. Contact tracing of perpetrators is a complex issue which should be addressed if possible with the help of a Health Advisor who can arrange provider referral if appropriate. This will require discussion with the client about our duty of care towards the client, the assailant and respective partners/sexual contacts. Contact tracing can be arranged via the investigating police officer bearing in mind that positive STI may have evidential potential and will require demonstrating a chain of evidence.

Men and Sexual Assault

There is limited evidence that men are at higher risk of acquiring HIV and other STIs following a sexual assault, but often they do not engage with medical care. Male sexual assault has been persistently under-reported due to embarrassment, male rape being a taboo and men expected to be emotionally 'strong'. Setting up a sensitive service with a choice of a gender of the examining healthcare professional may encourage men to disclose their assault. Sexually assaulted men often prefer to see and be examined by female staff; however, a choice of a male or female health care professional should be available to them if possible.

Vulnerable Groups

Groups vulnerable to sexual violence include the young and elderly, those with mental health problems, learning difficulties/disability, victims of domestic violence, ethnic minorities, trafficked women/commercial sex workers and those misusing alcohol and/or recreational drugs. Enquiries about such vulnerabilities will help to identify those in need of additional support and help to facilitate appropriate referrals to mental health services, general practitioners and support agencies. Access to interpreter and advocacy services may be helpful.

Young People and Sexual Assault

Rape amongst young people has been publicised by the media. Sexually assaulted young people typically have vulnerabilities, including mental health problems.

- Consider consent issues and assess Gillick competence in everyone who is under 16 years of age or under 18 with learning difficulties. If not Gillick competent, seek consent to examine the child from a person with parental responsibility or legal guardian.
- In children with learning difficulties/disabilities, seek paediatric advice.
- Liaison with community Child and Adolescent Mental Health Services (CAMHS), Child and Family Consultation Services (CFCS) and social services, may be necessary in order for effective child protection to occur in line with 'Working Together to Safeguard Children'.

Child Protection

Consider child protection issues and refer to social services when dealing with particularly vulnerable under-16 year olds (and those 17-18 year olds where there is a vulnerability concern or learning difficulties) who have disclosed a history of sexual assault or are children who have witnessed domestic or sexual violence. Under-13 year olds should be followed up by community paediatricians. Have available a contact lists of designated doctors for child protection in your area who will accept such referrals.

Domestic Violence and Sexual Assault

Domestic violence is strongly linked to rape. Almost 85% of violence against women crimes are domestic violence; 5% are rape and 11% sexual offences. Over 144,000 defendants were prosecuted for violence against women offences in the two years ending in March 2008.

A client-centered and multi-agency approach is often needed in handling such cases, with care taken to build trust and offer support when needed. The issue of child protection for children witnessing such abuse should not be ignored and appropriate risk assessment and referrals to agencies such as social services or the likes of a Multi-Agency Risk Assessment Conference (MARAC - a forum where multiple agencies provide a coordinated response) or Co-ordinated Action Against Domestic Abuse (CAADA - a national charity) should be made. See Appendix 1 in the original guideline document.

Ethnic Minorities and Sexual Assault

Rape amongst ethnic minorities is underreported and stigmatized. The maintenance of virginity may be an issue and the opportunity to marry after a

rape may be affected. This is complicated by language barriers (a family member should never be used to interpret for a client; they should be seen on their own or with an impartial interpreter), cultural issues, social isolation and family pressures. An understanding of local ethnic minority populations in your GUM/Sexual Health clinic catchment area is useful, as is access to language services and/or interpreters as well as having leaflets in other languages. The language barrier may be an issue in communication. Use an independent, professional interpreter whenever possible.

Female Genital Mutilation (FGM)

FGM refers to procedures which involve partial or total removal of the external female genitalia, or injury to the female genital organs for cultural or other non-therapeutic reasons. FGM is practiced in some African countries such as Egypt, Somalia, Ethiopia and Sudan. It is deemed a child protection issue as well as a criminal offence, a serious public health hazard and a human rights issue. Up to 24,000 young girls in the UK are at risk of FGM. It is illegal in the UK to subject a child to FGM or to take a child abroad to undergo the procedure. Females in the UK who have undergone FGM may be British citizens born to parents from FGM practicing communities, or they may be females living in Britain who are originally from those communities (e.g., women who are refugees, asylum seekers, overseas students or the wives of overseas students.) FGM is a safeguarding issue; inter-agency collaboration and communication is vital. Suspicion should be raised in cases of behavioral changes in a child, such as prolonged toilet visits (due to urinary symptoms) or sudden holidays abroad (for the FGM procedure). Where practitioners believe that an adult has undergone FGM they should also consider the risks to any children or young people who may be related to, or living with the woman. Whenever there is concern that a girl or young woman is at risk of harm through FGM, steps must be taken to safeguard them, following national and local guidelines. If a girl or young woman has already had the procedure performed and there are other female siblings in the family, a child-in-need referral may need to be made, following the steps outlined in 'What to do if you are worried a child is being abused'.

Safety Issues

Consider safety issues, particularly in cases of domestic violence, stranger or known assailant sexual assault, where there is fear of the assailant (or their friends and family) knowing the client's address and threatening or intimidating the client. Under these circumstances, advise the client to seek help from a local Community Safety Unit at the police station, who will offer advice on what to do, or install safety measures such as alarms at their home.

Psychological Consequences of Sexual Assault

Anxiety and depression after sexual assault appear early and are common. The majority recover whilst a minority will go on to develop PTSD. It is a diagnosable disorder (American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders [DSM IV], 1994) and occurs when a person has experienced, witnessed or has been confronted with an event that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others. The person's response involved intense fear, helplessness and horror. Symptoms can include persistent re-experiencing of trauma (such as thoughts and images), avoidance of stimuli associated with the trauma (such as talking or thinking about what happened) and numbing of general responsiveness, as well as persistent symptoms of increased arousal (such as concentration and memory problems, irritability, being easily startled and hyper vigilance to threat). Individuals with PTSD may also experience a range of other difficulties such as sleep and appetite disturbance, relationship difficulties, sexual dysfunction, low-mood, feelings of guilt, shame and self-blame, suicidal ideation and self-harm.

In one study, 20% of those who reported that they had been sexually assaulted gave a history of mental health problems. Factors that make individuals more vulnerable to developing PTSD include a previous history of sexual victimisation, a history of mental health difficulties including self-harm, lack of social support, a sense and/or evidence of ongoing threat (e.g., domestic violence and post-trauma life events). People who have been raped or sexually assaulted are much more susceptible to develop PTSD than any other trauma.

Psychosocial Support

Assessment of the psychosocial needs and coping can be done by any healthcare professional dealing with the client within a local GUM/sexual health clinic. Carrying out self-harm risk identification will help to establish the degree of risk and facilitate appropriate referrals (see Appendix 5 in the original guideline document). Those not coping, or who have vulnerabilities, should be referred to a health advisor, counselor, psychologist or general practitioner for support, depending upon their needs. An acute referral to mental health services may be necessary in those at high risk of suicide. Some SARCs have Crisis Workers or Young Persons Support Workers who offer advice and support, others are Independent Sexual Violence Advisors (ISVAs) or Child and Young People Sexual Violence Advisors who offer practical support. Rape Crisis (see Appendix 1 in the original guideline document) offers emotional support to anyone who has been sexually assaulted.

Follow Up in the Community

Communication with the client's GP – with consent – to assure continuity of care, should be encouraged. Enquire the reasons for any client

declining a GP referral/notification and explain why such a referral may be beneficial (e.g., added support in the community if risk of self-harm has been identified or completion of hepatitis B vaccination, if unwilling or unable to attend for follow up in the clinic).

Voluntary Organisations

Information about local victim support organisations such as: Rape Crisis Centers, The Samaritans, Survivors and Victim Support should be present to facilitate referral, if needed (see Appendix 1 in the original guideline document)

Criminal Injuries Compensation Authority

The Criminal Injuries Compensation Authority is a government body responsible for administering the UK Criminal Injuries Compensation Scheme. It provides a free service to victims of violent crime who may be interested in applying for financial compensation. See www.cica.gov.uk .

Definitions:

Levels of Evidence

Level	Type of Evidence
Ia	Evidence obtained from meta-analysis of randomised controlled trials
Ib	Evidence obtained from at least one randomised controlled trial
IIa	Evidence obtained from at least one well-designed controlled study without randomisation
IIb	Evidence obtained from at least one type of well-designed quasi-experimental study
III	Evidence obtained from well-designed, non-experimental descriptive studies, such as comparative studies, correlation studies and case control studies
IV	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Grades of Recommendation

Grade	Recommendation
A (Evidence levels Ia, Ib)	Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation
B (Evidence levels IIa, IIb, III)	Requires availability of well-conducted clinical studies but no randomised clinical trials on the topic of recommendation
C (Evidence level IV)	Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates absence of directly applicable studies of good quality

Clinical Algorithm(s)

The following algorithms are provided in Appendices 3 and 4 of the original guideline document:

- Disclosure of Information Algorithm
- Sexual Assault Referral Pathways

Scope

Disease/Condition(s)

Sexual assault, including:

- Sexually transmitted infections and/or pregnancy following sexual assault

- Psychological sequelae of sexual assault

Guideline Category

Counseling

Evaluation

Management

Prevention

Risk Assessment

Screening

Treatment

Clinical Specialty

Emergency Medicine

Family Practice

Infectious Diseases

Internal Medicine

Obstetrics and Gynecology

Preventive Medicine

Psychiatry

Psychology

Urology

Intended Users

Hospitals

Physician Assistants

Physicians

Guideline Objective(s)

To provide information on the initial assessment and aftercare (including psychosocial support) of those who disclose a history of sexual assault to healthcare professionals in the setting of genitourinary medicine (GUM)/sexual health clinics* in the United Kingdom

*Note: It may also be useful for other health professionals who find themselves managing complainants of sexual assault.

Target Population

Sexually assaulted adults of both sexes but the forensic aspects can also be applied to adolescents*

*For the specific management of sexually transmitted infections (STIs) in adolescents, refer to the current British Association for Sexual Health and HIV (BASHH) guidelines and to the Royal College of Paediatrics and Child Health Handbook.

Interventions and Practices Considered

Evaluation/Diagnosis

1. Brief history of the assault
2. Consent, confidentiality, and disclosure of notes
3. Physical examination
    - Genital or peri-anal inspection and noting injuries/signs of infection
    - Inspection of the oral cavity
    - Proctoscopy (in cases with a history of anal penetration)
4. Laboratory investigations for sexually transmitted infections (STIs)
    - Cultures for *Neisseria gonorrhoeae* and nucleic acid amplification tests (NAAT) for *Chlamydia trachomatis*
    - Vaginal wet slides for microscopy for yeasts, bacterial vaginosis, and *Trichomonas vaginalis* (TV)
    - Serology testing for syphilis, hepatitis B and C, and HIV

Management/Treatment/Prevention

1. Prophylaxis of bacterial and viral STIs
2. Human immunodeficiency virus (HIV) post-exposure prophylaxis after sexual exposure (PEPSE)
3. Prophylaxis of hepatitis B infection
4. Pregnancy prevention
5. Partner notification
6. Psychosocial support
7. Follow-up

Major Outcomes Considered

- Incidence of sexually transmitted infection (STI) following sexual assault
- Completeness of documentation of assault and patient management
- Incidence of post-traumatic stress disorder (PTSD) following sexual assault
- Incidence of side effects from prophylaxis
- Incidence of pregnancy from sexual assault
- Sensitivity and specificity of diagnostic tests

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Evidence was sought from Medline, Cochrane library and Google search as well as websites such as the United Kingdom (UK) Department of Health. Searches were made from 1980 to 2009 using key words: Sexual Assault, Rape, Sexually Transmitted Infections, post exposure prophylaxis, HIV infection, Hepatitis B infection, Adult, Adolescent, Male, Client care, PTSD, Psychological, Domestic violence. Additional papers identified by searches were also reviewed.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

Level	Type of Evidence
Ia	Evidence obtained from meta-analysis of randomised controlled trials
Ib	Evidence obtained from at least one randomised controlled trial
IIa	Evidence obtained from at least one well-designed controlled study without randomisation
IIb	Evidence obtained from at least one type of well-designed quasi-experimental study
III	Evidence obtained from well-designed, non-experimental descriptive studies, such as comparative studies, correlation studies and case control studies
IV	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

The following provided input into the original draft document: senior physicians in genitourinary medicine, clinical nurse specialists, a health advisor/counselor, clinical psychologists, clinical directors of United Kingdom (UK) sexual assault referral centers, members of the Faculty of Forensic and Legal Medicine, a senior police officer from the specialist Sapphire Unit in the Metropolitan Police, Sexual Assault Referral Center (SARC) development project manager in the Department of Health, Victim Support (an independent UK charity) and a service user who has chosen to remain anonymous to protect her confidentiality.

Rating Scheme for the Strength of the Recommendations

Grades of Recommendation

Grade	Recommendation
A (Evidence levels Ia, Ib)	Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation
B (Evidence levels	Requires availability of well-conducted clinical studies but no randomised clinical trials on the topic of recommendation

Grade	Recommendation
C (Evidence level IV)	Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates absence of directly applicable studies of good quality

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The draft document underwent consultation with the genitourinary (GU) medicine specialty and the public via the British Association for Sexual Health and HIV (BASHH) website for 3 months. Comments and feedback were taken into account in producing the final document.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is graded and identified for one of the recommendations (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate initial assessment and aftercare (including psychosocial support) of persons in the United Kingdom who have experienced a sexual assault

Potential Harms

- Clinicians should be aware of the potential for false-positive nucleic acid amplification test (NAAT) results regardless of the site tested, particularly when using the test in a low prevalence population.
- Disadvantages of prophylaxis for bacterial sexually transmitted infections include unnecessary treatment, reinforcing belief that there was a high risk of infection (which in itself may raise levels of anxiety) and missing out on partner notification, if the source of infection was someone other than the assailant, leading to the possibility of re-infection by a regular or known sexual partner.
- Advice should be given concerning the lack of conclusive data about the efficacy and long-term toxicity of HIV post-exposure prophylaxis after sexual exposure (PEPSE), as well as possible side effects. Side effects include nausea, vomiting and diarrhoea.
- Kaletra® (lopinavir and ritonavir) reduces the effect of the contraceptive pill through induction of hepatic enzyme activity.
- Disclosure of counseling or psychology notes for court purposes may generate anxiety about the potential impact they may have on criminal proceedings, due to the very personal nature of such consultations. It is important to balance protecting the client's confidentiality with assisting the criminal justice system.

Qualifying Statements

Qualifying Statements

- These guidelines must be interpreted with a degree of flexibility dependent upon the assessment of the emotional and physical state of the presenting person, as well as the risk of infection. A pragmatic and compassionate approach is needed for someone who may be desperately trying to regain control after the assault. The benefit of any investigation must be weighed up against the risk of exacerbating or prolonging distress.
- Drug treatment regimens and screening and testing guidance for sexually transmitted infections are rapidly changing areas. Advice given in this document was correct at the time of publication; however, the reader is advised to check the most up-to-date guidance from BASHH at www.bashh.org/guidelines.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Audit Criteria/Indicators

Clinical Algorithm

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Timeliness

Identifying Information and Availability

Bibliographic Source(s)

Clinical Effectiveness Group. UK national guidelines on the management of adult and adolescent complainants of sexual assault 2011. London (UK): British Association for Sexual Health and HIV; 2012 Jun. 50 p. [92 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

1999 Aug (revised 2011; republished 2012 Jun)

Guideline Developer(s)

British Association for Sexual Health and HIV - Medical Specialty Society

Source(s) of Funding

This guideline was commissioned, edited and endorsed by the British Association for Sexual Health and HIV (BASHH) Clinical Effectiveness Group (CEG) without external funding being sought or obtained.

Guideline Committee

Clinical Effectiveness Group (CEG)

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Financial Disclosures/Conflicts of Interest

Dr Jan Welch has received occasional editorial fees for work with the British Medical Journal electronic guidelines on sexual assault. She is also a member of the United Kingdom (UK) Department of Health Violence Against Women and Children Implantation Group. No other declarations of interest were declared by the other principal authors.

Guideline Status

This is the current release of the guideline.

This guideline updates a previously version: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guidelines on the management of adult victims of sexual assault. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p. [19 references]

Guideline Availability

Electronic copies: Available from the British Association for Sexual Health and HIV Web site .

Availability of Companion Documents

The following is available:

- British Association for Sexual Health and HIV: framework for guideline development and assessment. British Association for Sexual Health and HIV; 2010. 18 p. Electronic copies: Available in Portable Document Format (PDF) from the BASHH Web site .

In addition, auditable outcomes are provided in the original guideline document .

Patient Resources

None available

NGC Status

This summary was completed by ECRI on December 8, 2000. The information was verified by the guideline developer on January 12, 2001. This summary was updated on August 5, 2002. This NGC summary was updated by ECRI Institute on June 6, 2012. This summary was updated by ECRI Institute on October 25, 2013 following the U.S. Food and Drug Administration advisory on Fluoroquinolone Antibacterial Drugs. This summary was updated by ECRI Institute on May 18, 2016 following the U.S. Food and Drug Administration advisory on Fluoroquinolone Antibacterial Drugs.

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